



1981 E Palmer-Wasilla Hwy, Suite 220, Wasilla, AK 99654
Phone: (907) 357-6513 | Fax: (907) 357-6514

INSTRUCTIONS

1. Please read the important Notice Regarding Privacy Practices and Client Rights before printing any of your Intake documents. You will have an opportunity to discuss any questions about this notice and all your intake forms at your first appointment.

2. Please thoroughly read, sign, and submit the following required forms to Olive Tree Counseling's office before your first session.
 - a. Electronic Communications Consent Forms
 - b. Authorization for Treatment
 - c. Agreement Regarding Information for Court
 - d. Agreement to Pay for Professional Services
 - e. Acknowledgement of Receipt of Notice of Privacy Practices and Client Rights
 - f. Acknowledgement of Receipt of Intake Forms
 - g. Intake: General Information Packet

As a client sharing confidential and protected information with our facility, it is in your best interest to thoroughly read and understand all the contents of this packet.

Thank you. Sincerely,

Olive Tree Counseling, Inc.

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW CAREFULLY AND **KEEP FOR YOUR RECORDS**.

*Because Olive Tree Counseling, Inc. (aka, OTC) sees clients under 18, all references to "you" include your child as the parent or guardian of the child. A parent or guardian may exercise the rights of the minor or child.

OTC understands that your health information is personal to you, and OTC is committed to protecting your information. This Notice of Privacy Practices and Client Rights (aka, Notice) describes how OTC will use and disclose protected information and data OTC receives or creates related to your health care.

OUR DUTIES

OTC is required by law to maintain the privacy of your health information and to give you this Notice describing our legal duties and privacy practices. OTC is also required to follow the terms of this Notice currently in effect.

USE AND DISCLOSURE OF HEALTH INFORMATION

OTC will not use or disclose your health information without your authorization except in the following situations:

TREATMENT

OTC may use and disclose your health information while providing, coordinating, or managing your health care. Information obtained by a member of your counseling team will be documented in your record and used to determine the course of treatment that should work best for you. OTC may also provide other healthcare providers with the minimum information that will assist them in treating you.

PAYMENT

OTC may use and disclose your medical information to obtain or offer payment for providing your health care. If OTC sends you or your health plan a bill, the information on or accompanying the bill may include information that identifies you, your diagnosis, procedures, or supplies used. OTC may be required to disclose information to your health plan to determine your eligibility for payment for certain benefits. Please note: some insurance companies request detailed information and others request only a diagnosis and office visit codes. It is your responsibility to know what personal information is required by your insurance company.

HEALTH CARE OPERATIONS

OTC may use and disclose health information to deal with certain administrative aspects of your health care and to manage our business more efficiently. OTC's medical staff may use information in your health record to assess the quality of care and outcomes in your case and others like it. This information will be used to improve the quality and effectiveness of the healthcare and services OTC provides.

BUSINESS ASSOCIATES

OTC may disclose your health information to its business associates to perform the job OTC has asked these associates to do, such as accounting or legal analysis. However, OTC requires the business associates to take precautions to protect your health information.

NOTIFICATION OF FAMILY

In an emergency, OTC may use or disclose information, your location, or general condition to notify or assist a family member, personal representative, or other person responsible for your care.

COMMUNICATION WITH FAMILY

OTC may disclose to a family member, relative, friend—or other person with whom you identify—health information relevant to said individual's involvement in your care.

COURT PROCEEDING

OTC may disclose your health information in response to requests made during judicial and administrative proceedings, court orders, or subpoenas as required by law.

OTHER USES

OTC may use and disclose your personal health information for the following purposes:

- Leave messages for patients regarding upcoming appointments or other administrative matters at the contact numbers on file.
- Describe or recommend treatment alternatives to you.
- Provide information about health-related benefits or services that may be of interest.

Rarely, OTC may disclose information for Food and Drug Administration (FDA), public health, reporting abuse, neglect or domestic violence, health oversight, law enforcement, threats to public health or safety, and specialized government functions (military, national security).

PROHIBITION ON OTHER USES OR DISCLOSURES

OTC will not make any other use or disclosure of your personal health information without your written authorization. Your name and identity will only be disclosed in accordance with AS 08.29.200. Once given, you may revoke the authorization in writing. OTC is unable to reverse any disclosure that has been made previously with your permission.

CONFIDENTIALITY AND PRIVACY

Confidentiality at OTC is maintained according to the AAMFT Code of Ethics, State Professional Counseling regulations and HIPAA regulations. OTC cannot guarantee that your data will be kept private where disclosing information is required by law. There are limits and exceptions to confidentiality. Understand what can and cannot be kept private:

1. When you or another person is in physical danger, OTC is required by law to report it. OTC will reveal the minimum information necessary to protect you or other individuals.
2. If OTC has reason to believe you are threatening harm to another person, OTC is required by law to protect said person. OTC is required to inform said person and the police, or have you hospitalized.
3. If you threaten or act in a way likely to harm yourself, OTC may have you hospitalized or call family to protect you. If such a situation does occur, OTC will attempt to fully discuss the situation with you before acting unless there is an exceptional reason not to.
4. In an emergency where your life or health is in danger, and OTC cannot get your consent, OTC may give another professional minimum information to protect your life. OTC will attempt to get permission first and discuss the situation as soon as possible.
5. If OTC suspects you are abusing a child, elderly person, or disabled person, the law requires OTC to file a report with a state agency. Abuse includes neglect, physically assault, or sexually molest another

person. OTC does not have any legal power to investigate the situation. Discuss legal aspects in detail before you disclose anything to OTC. Consider speaking with a lawyer.

Other considerations regarding confidentiality and treatment:

- OTC may consult with a qualified individual about your treatment without providing your name. Likewise, when OTC is unavailable, another therapist may have access to client records at the client's request. Your information will remain protected under HIPAA guidelines.
- OTC is required to keep records and notes of your treatment. If you have specific or unusual concerns, please speak with your own attorney—OTC does not give legal advice.
- OTC sees people individually, as couples, or as families. OTC will keep information confidential except for the previously listed situations. However, if others need the information for your continued progression in therapy, OTC may encourage and work with you to disclose relevant information.

RECORDS REQUESTS FOR MINORS

While parents have the legal right to receive information their children share in therapy, for the mental wellbeing of the child, OTC encourages parents to not request this data. OTC may encourage and assist children in sharing information, but OTC will not share data unless necessary to protect the life and wellbeing of an individual. OTC does not believe it is in a child's best interest to release therapeutic records in most cases. OTC's code of ethics prohibits harm to clients; therefore, OTC will not willingly release records unless required by law. Clients do not feel safe when information is passed on to family or if information disclosed in therapy is used in court proceedings. Therefore, OTC reserves the right to review or reject any request for records where compliance is not lawfully required.

OTHER RECORDS REQUESTS

OTC does not release marriage and family therapeutic records to spouses without both spouses' written consent. Only your own individual records are available for you to request. However, it is not in the best interest of an individual to obtain therapeutic records—any request for records with which OTC is legally obligated to comply will include a written statement declaring that you were informed as such.

INDIVIDUAL PRIVACY RIGHTS

Clients have the right to confidentiality of client health information. As a client, you have the right to:

1. Request restrictions on the health information OTC may use and disclose for treatment, payment, and health care operations. OTC is not required to agree to these requests. To request restrictions, please send a written statement to the address listed at the end of this document.
2. Receive confidential communications of health information about you in a certain manner or at a certain location. For instance, you may request that OTC only contact you at work or by mail. To make such a request, you must write the address listed at the end of this document stating how or where you wish to be contacted.
3. Inspect or copy your health information in paper or electronic form. You must submit your request in writing to the address listed at the end of this document. If you request a copy of your health information, OTC will charge a fee for the cost of copying, mailing, and other supplies. OTC reserves the right to deny

your request to inspect or copy your health information. However, you may request that the denial be reviewed by a separate licensed professional. OTC will comply with the outcome of their review.

4. Amend health information. If the health information that OTC has on record is incorrect or incomplete, you may ask to amend the information. To request an amendment, you must write to the address at the end of this document with the reason to support your request. OTC may deny your request to amend your health information if it is not in writing or a reason to support your request is not provided. OTC may also deny your request if:
 - a. The information was not created by OTC, unless the person that created the information is no longer available to make the amendment.
 - b. The information is not part of the health information kept on record by or for OTC.
 - c. It is not part of the information you are permitted to inspect or copy.
 - d. It is accurate and complete.
5. To receive an accounting of disclosures of your health information. You must submit a request in writing to the address listed at the end of this document. Not all health information is subject to this request. Your request must state a time no longer than 6 years and may not include dates before April 14, 2003, and how you would like to receive the report (paper or electronically).
6. There is no charge for your first accounting request. For additional accountings, OTC may charge you the cost of providing this service. OTC will notify you of this cost, and you may choose to withdraw or modify your request before any charges are made.
7. To receive a paper copy of this Notice upon request—even if you have agreed to receive the Notice electronically—you must submit a request for a paper Notice in writing to the address listed at the end of this Notice.

All requests to restrict use of your health information for treatment, payment, and health care operations, to inspect and copy health information, to amend your health information, or to receive an accounting of disclosures of health information must be made in writing to the contact person listed at the end of this Notice.

OTHER CLIENT RIGHTS

As a client, you have the right to:

1. Be treated with respect regarding psychosocial, spiritual, and cultural variables that influence perceptions.
2. Have a safe environment, free from discrimination of race, color, religion, gender, sex, handicap, national origin, or political standing. OTC treats individuals with respect and recognizes basic human rights.
3. Receive information about therapist qualifications, including license, education, training experience, membership in professional groups, special areas of practice, and limits of practice.
4. Have written information about fees, methods of payment, insurance coverage, and number of sessions the therapist thinks will be needed, and cancellation policies.
5. Have informed consent to procedures, benefits and risks, and alternative options for your care.
6. Privacy and confidentiality of your assessment and records, with exceptions noted in this document.
7. Refuse audio or video recordings of sessions.
8. Ask the therapist to inform you of your progress.
9. Report any illegal or immoral behavior by a therapist.

PROPER AND IMPROPER THERAPIST CONDUCT

A therapist should never use threatening or coercing behavior as part of your treatment plan. If you feel threatened by your therapist, confront it immediately and contact OTC's office at (907) 357-6513.

It is normal for clients to develop positive feelings or affection toward a therapist giving clients support and care. However, these feelings may take negative forms of sexual attraction. Sexual contact with your therapist is prohibited and is harmful to the client and therapist. Sexual contact is against the professional code of conduct for all professional groups of mental health workers (i.e., psychologists, psychiatrists, licensed counselors, and marriage and family counselors). You are encouraged to contact OTC's office for more information on any of OTC's therapists or to file a complaint.

NO GUARANTEED OUTCOME

OTC strives to help clients reach the goals they desire. However, therapy does not guarantee success. OTC will do its best to help you or will refer you to someone who can. Consequences not considered ideal, such as divorce, are a possibility. OTC will do its best to encourage the best possible outcomes with the least discomfort. If therapy seems ineffective, OTC will explore alternative therapy or resources for you.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint at (907) 357-6513 or to the address listed below. For severe violations, submit a complaint to the Secretary of the Department of Health and Human Services. OTC will not retaliate against you for filing a complaint.

CONTACT PERSON

The following OTC's contact person for all written questions, requests, or further information related to the privacy of your health information:

Holly Hoff

1981 E. Palmer-Wasilla Hwy. Suite 220

Wasilla, AK 99654 Attn: Privacy Officer

Office: (907) 357-6513 | Fax: (907) 357-6514

CHANGES TO THIS NOTICE

OTC reserves the right to change its privacy practices and apply revisions to previous health information. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility.

Effectiveness date: Jan. 2025. Reviewed and revised: July 2024.



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PATIENT CONSENT TO ELECTRONIC COMMUNICATIONS

Any use of electronic communication must be pre-approved by Olive Tree Counseling, Inc. (aka, OTC), in agreement with the client, documented in writing, and kept in the client's records.

Full Name: _____

*If I (the client) authorize email, text, and other online communications, I understand that:

1. Remote and online communication be misdirected to or intercepted and disclosed by unintended third parties and, therefore, may not be a confidential medium of communication.
2. Patients who have concerns should consider using another mode of communication.
3. Patients understand and agree that email and text transmission is being used for the convenience of the patients. OTC does not require the use of email or text, nor does it guarantee the confidentiality and/or the security of any remote transmission of information.
4. Patients, notably those patients who have multi-user devices and/or accounts, are responsible for maintaining the confidentiality and security of their own devices and/or accounts. OTC is not responsible for information breaches on the end of patients' personal devices and/or accounts.
5. Regardless of whether the patient wishes to communicate with OTC via email, it is recommended that patients provide a working and up-to-date email address. Protected information will not be discussed via email without first being authorized by the patient (Please check your Junk mail inbox periodically).

***Do you (the client) wish to communicate with OTC via email, text, fax, or online services?**

- Yes, I authorize EMAIL via the address: _____
- Yes, I authorize TEXTING via the phone #: _____
- Yes, I authorize FAX via the following #: _____
- No, I do NOT authorize any online communications with OTC.

Telehealth & Online Services Terms and Conditions

I (the client) understand that this consent form must be filled in its entirety regardless of whether I wish to receive telehealth treatment. OTC is not liable for any claims and/or damages arising from the optional use of telehealth services. Telehealth services are *entirely voluntary* and will not influence the quality of care the client will receive from OTC, or condition treatment or payment on the optional use of telehealth services.

Alaska Telehealth/Telemedicine Definition, Alaska policy and regulations telemedicine references; Senate Bill 74 defines telehealth/telemedicine as the practice of health care delivery, evaluation, diagnosis, consultation, or treatment using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the recipient or from each other, or between a provider and a recipient who are physically separated from each other.

*As a client receiving behavioral health services through online technologies, I (the client) understand that:

1. The interactive technologies used in tele-behavioral health incorporate network and software security protocols to protect the confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard data and protect against intentional or unintentional corruption.
2. This service is provided by technology and may not involve direct, face-to-face communication. There are benefits and limitations to this service, such as the following:
 - a. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.
 - b. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
 - c. In emergencies, disruption of services, or for routine or administrative reasons, it may be necessary to communicate by other means, i.e., through the cell phone number provided by the client.
 - d. In the event of disruption of services, the client must attempt to re-establish service at least twice before attempts to communicate via cell phone.
3. The client will need access to, and familiarity with, the appropriate technology to participate in the service provided.
4. The exchange of information will not be direct, and any paperwork exchanged will likely be provided through electronic means or through postal delivery.
5. During my (client) tele-behavioral health consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals using interactive video, audio, or another telecommunications technology.
6. If a need for direct, in-person services arises, it is my responsibility to contact my practitioner or practitioners in my area, such as another provider in my behavioral practitioner's office, or secure an appointment with my primary care physician if my behavioral practitioner is unavailable. I understand that an opening may not be immediately available in other offices.
7. My practitioner and I will regularly reassess the appropriateness of continuing the online services agreed upon, and we will modify the treatment as needed.
8. It is my responsibility to maintain privacy on my end of communication. However, I understand that insurance companies, those authorized by me (the client), and those permitted by law may also have access to records or communications.
9. I may decline or discontinue any tele-behavioral health services at any time without jeopardizing my access to future care, services, and benefits.
10. Records of my communications and sessions will be stored in the same secure manner that face-to-face records are stored.
11. The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

12. As the client, I understand the security of online communications is a two-way responsibility. My therapist will keep my communications private and secure on my therapist's end. However, it is *also my responsibility* to keep online communications private and secure on my end.

**Please list an example of how you (the client) will ensure all online communications will be kept private and directed only between you and your mental health provider or other authorized individuals (e.g.: I will keep my door locked and wear a headset. I will not let unauthorized individuals check my phone or email messages.)*

I (the client) will ensure privacy by:

E.g.: _____

***I (the client) acknowledge that I have thoroughly read, understood, and agreed to OTC's PATIENT CONSENT TO ELECTRONIC COMMUNICATIONS terms and conditions. I understand the benefits and risks associated with online communications and consent to the conditions as indicated herein. I agree to adhere to the policies set forth above, as well as any other instructions or guidelines that OTC may impose for using electronic communications.**

(Signature required regardless of opt-in/opt-out online communications status)

Printed name of Client	Signature of Client	Date
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Signature of parent or guardian if applicable	Relationship to client (if necessary)	Date
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____Holly Hoff, LPC ____Brittney Punt, LCSW ____Ken Brewington, LPC ____Keri Chandler, LPC

Printed name of Staff	Signature of Staff	Date
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ELECTRONIC COMMUNICATIONS: Text-To-Pay Authorization

*** IF YOU DO NOT WISH TO SIGN UP FOR TEXT-TO-PAY, PLEASE DISREGARD THIS PAGE ***

To always stay up to date with payments, OTC offers an optional **Text-To-Pay** service as a courtesy to the client. OTC utilizes this service through the online platform, *Office Ally*, powered via *STRIPE*, and is certified HIPAA compliant. However, as outlined above, texting is *fundamentally* not a secure method of communication and is only used at the clients' convenience and discretion.

If I (the client) sign up for **Text-To-Pay**, I acknowledge and understand the following agreement (please initial):

_____ I understand that texting is NOT a secure form of communication and the inherent risks associated, and
(initial) I agree that OTC will not be held responsible for information breaches on my end.

_____ I understand the use of **Text-To-Pay** is completely optional and is only offered for my own personal
(initial) convenience, and it does not affect the price or quality of the service I receive.

_____ I understand that I may opt-out of **Text-To-Pay** at any time with no penalty by contacting OTC via phone,
(initial) email, letter, or verbally.

_____ I understand that OTC will only text the number to which I have already given authorization outlined in the
(initial) CONSENT TO ELECTRONIC COMMUNICATIONS form that has been provided to me.

My signature below shows that I wish to enroll in **Text-To-Pay**, and that I understand and agree to the above terms.

Printed name of Client	Signature of Client	Date
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Signature of parent or guardian if applicable	Relationship to client (if necessary)	Date
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___Holly Hoff, LPC ___Brittney Punt, LCSW ___Ken Brewington, LPC ___Keri Chandler, LPC

Printed name of Staff	Signature of Staff	Date
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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES AND CLIENT RIGHTS**

By signing below, I acknowledge that I have received Olive Tree Counseling, Inc.'s NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS, and I understand and have had an opportunity to ask questions about the Notice, rights, therapist conduct, and other information in the Notice.

Printed name of Client	Signature of Client	Date
------------------------	---------------------	------

Signature of parent or guardian if applicable	Relationship to client (if necessary)	Date
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I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

___ Holly Hoff, LPC ___ Brittney Punt, LCSW ___ Ken Brewington, LPC ___ Keri Chandler, LPC

Printed name of Staff	Signature of Staff	Date
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Authorization to Treat a Minor by Parent or Legal Guardian

I, _____ (name), confirm that I am the parent or law-appointed legal guardian, and have legal authority and rights to make decisions on behalf of _____ (minor), hereafter referred to as MINOR, and treatments MINOR receives. I acknowledge that I have received, read (or have had read to me), and understand the information provided about the therapy I am considering for MINOR and have had all questions answered fully.

I do hereby seek and consent to allow MINOR to take part in the treatment provided by OTC with the therapist indicated below. I understand that a treatment plan will be developed with a therapist and a regular review of progress toward meeting the treatment goals are in MINOR’s best interest. I understand that no promises have been made to me as to the results of treatment or of any procedures provided at OTC.

I am aware that, as the parent or legal guardian, I may stop MINOR’s treatment with OTC at any time. The financial obligation for the services received shall fall under the responsibility of the parent who is initially seeking MINOR’s treatment. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments MINOR receives.

My signature below shows that I understand and agree to the above terms.

Printed name of Client Signature of Client Date

Signature of parent or guardian if applicable Relationship to client (if necessary) Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____Holly Hoff, LPC ____Brittney Punt, LCSW ____Ken Brewington, LPC ____Keri Chandler, LPC

Printed name of Staff Signature of Staff Date



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Fees for Professional and Administrative Services

Olive Tree Counseling, Inc. Fees

Initial Assessment	\$350.00	No Call No Show	Service cost
60-minute sessions	\$200.00	Art Therapy	\$220.00
45-minute sessions	\$160.00	Play Therapy	\$220.00
30-minute sessions	\$100.00		

Olive Tree Counseling, Inc. Administrative / Court Fee Schedule:

Copies per page	\$.50
Summary of Care Reports	\$ 100.00
Court appearances are hourly (Point to point)	\$ 2000.00

I agree that I am responsible for fees of service provided by OTC. My insurance company may make payments on my account; however, under HIPAA guidelines, I understand that other persons—be it friend, spouse, or family—may not make payments on my behalf without necessary authorization in a RELEASE OF INFORMATION. I also understand that OTC reserves the right to change the Fee Schedule and Terms of Payment at any time, and I will be provided with the new Fee Schedule and Terms at the next applicable visit. I am aware that I may stop my treatment any time but will still be responsible for paying for services I have already received. Should I not comply with my responsibility to pay for services, OTC reserves the right to provide my demographic data and financial information to a collection agency.

Insurance Information

I understand that OTC will bill my primary insurance as a courtesy. I understand my insurance will be provided with personal information regarding services received at OTC. I have been informed and understand that OTC does not bill secondary insurance companies. However, I may request OTC to provide claim forms for me submit to secondary insurances myself. I understand that I will be responsible for fees not covered by my primary insurance. I request OTC to bill my insurance company for services I receive.

No Call No Show

I understand it is my responsibility to cancel an appointment *before* the time of the appointment. If I do not cancel in advance and do not show up, I will be charged for that appointment. Late cancellations will be reviewed on a case-by-case basis. I acknowledge that I received a copy, thoroughly read, and understand the Fee Schedule of OTC, and agree to comply with the terms listed above.

My signature below shows that I understand and agree to the above terms.

Printed name of Client _____ Signature of Client _____ Date _____

Signature of parent or guardian if applicable _____ Relationship to client (if necessary) _____ Date _____

____ Jody Rossing ____ Holly Hoff, LPC ____ Brittny Punt, LCSW ____ Ken Brewington, LPC ____ Keri Chandler, LPC

Printed name of Staff _____ Signature of Staff _____ Date _____



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COURT & DISCLOSURE STATEMENT AGREEMENT Minors, Couples, Families

OTC does not make recommendations to the court concerning divorce, custody, or parenting issues—the court appoints professionals to conduct such evaluations, and you may request an evaluation through your attorney if necessary. The purpose of the following agreement is to avoid harming the clinical relationship between clients, including couples, children, and families, and their therapist. Therefore, OTC will notify and discuss with all clients and couples with children of the following:

I (the client) acknowledge and understand the following agreement (please initial):

_____ I understand that the information the therapist gains from working with me, my family, and/or my child
(initial) is confidential, and that OTC will not release this information without my written authorization.

_____ I agree to not request any information from OTC for **any** court-related reason whatsoever, including but
(initial) not limited to divorce or custody issues except in required cases, such as threat of bodily injury.

_____ OTC may share a minor’s relevant information to a parent or legal guardian with the minor’s written
(initial) consent. However, I agree that this information will not be used in court except in required cases.

_____ I understand that it is not the role of a therapist to make recommendations to court or judge nor to express
(initial) opinions concerning divorce or custody issues.

My signature below shows that I understand and agree to the above terms.

Printed name of Client Signature of Client Date

Signature of parent or guardian if applicable Relationship to client (if necessary) Date

____Holly Hoff, LPC ____Brittney Punt, LCSW ____Ken Brewington, LPC ____Keri Chandler, LPC

Printed name of Staff Signature of Staff Date



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Acknowledgement of Receipt of Intake Forms

I, the client, acknowledge I have read, or have had read to me, and been offered copies of my Intake Forms, which include:

1. Notice of Privacy Practices & Client Rights
2. Patient Consent to Electronic Communications
3. Fees for Professional & Administrative Services
4. Authorization for Treatment
5. Court & Disclosure Statements

My signature below shows that I understand and agree to the above terms.

Printed name of Client	Signature of Client	Date
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Signature of parent or guardian if applicable	Relationship to client (if necessary)	Date
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I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____Holly Hoff, LPC ____Brittney Punt, LCSW ____Ken Brewington, LPC ____Keri Chandler, LPC

Printed name of Staff	Signature of Staff	Date
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INTAKE: GENERAL INFORMATION

A. Date: _____ Primary Language: _____
B. Your Name: _____ Date of Birth: _____ Age: _____ Soc Sec# _____
Spouse's Name: _____ Date of Birth: _____ Age: _____ Soc Sec# _____
Home Address: _____ City, State, Zip: _____
Mailing Address: _____
Home Phone: _____ Cell Ph: _____ Email address: _____
Current Employer: _____ Work Phone: _____
Insurance Carrier _____ Group # _____ ID# _____
Schedule/Best times for appointments: _____

Your Education, Training, or Military experience: _____

Minors

Child's Name: _____ Date of Birth: _____ Age: _____ Soc Sec# _____
Child's Biological Parent if different than above: _____
Biological Parent Date of Birth: _____ Biological Parent Social Security # _____
Home Address: _____
Mailing Address: _____ Phone: _____

Referral Information

Name: _____ Relationship _____ Phone: _____
How did this person explain OTC might be of service? _____

Chief Concern

Please describe the primary concerns prompting you to seek therapy:

D. Your two most important goals _____

E. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

NO ____ YES ____ if yes, Please indicate:

When/Dates	From Whom?	For What?	With What Results?
_____	_____	_____	_____
_____	_____	_____	_____

F. Have you ever taken medications for psychiatric or emotional problems? No ____ Yes ____

Medication Name	Prescribed by whom?	For What?	With What Results?
_____	_____	_____	_____
_____	_____	_____	_____

Child Checklist of Characteristics

Child's Name: _____ Date: _____ Child's Age: _____

Person completing this form: _____ Relationship to child _____

This form is to be completed by parents for their children. Please mark all the items that apply to this child and elaborate on any field you deem necessary.

1. Recent change in personality or character traits.
2. Recent life-style changes: moving, new school, loss of friends.
3. Self-harming: cutting or scratching skin, biting self, head banging, pulling out hair.
4. Suicide talk or attempts, *elaborate:* _____

5. Sexualized or flirtatious behavior, esp. those which do not appropriately reflect age, *elaborate:* _____

6. Aggressive to people and/or animals, intimidation or physically cruel or violent, *elaborate:* _____

7. Physical destruction of inanimate objects, toys, or property.
8. Immature or maturity does not appropriately reflect actual age.
9. Sudden shifts or fluctuations in mood or attitude, i.e., calm and abruptly becomes angry or violent.
10. Deceitfulness, thievery, shoplifting, or pathological lying.
11. Runs away, truant from school, eloping, or staying out all night.
12. Lacks emotional regulation, temper tantrums, rages, screams, etc. at inappropriate times.
13. Often disrespectful with adults, teachers, law enforcement. Does not respect authoritative figures.
14. Often disrespectful of requests or rules, defiant, disobedient, or refuses to comply generally.
15. Often deliberately annoys others, enjoys causing discomfort, or even sadistic tendencies.
16. Often blames others for his/her own mistakes or misbehavior, lack of accountability.
17. Often angry, resentful, or spiteful, vindictive, vengeful, tendencies for retaliation, or easily annoyed.
18. Often bitter, dark, and/or bleak attitude or overall outlook.
19. Often expresses self-hate, low self-esteem, or feelings of worthlessness and/or hopelessness.
20. Often sickly or frequently expresses upset stomach or undue flu-like symptoms.
21. Overly worried, anxious, or fearful, or irrationally so.
22. Overly impulsive, rash decisions, or struggles with self-regulation in general.
23. Overly humorous, funny, minimizing seriousness of events, struggles acting appropriately.
24. Overly impatient, cannot wait his/her turn or becomes unreasonably irritated by waiting.
25. Overly sensitive, sad, cries easily or frequently, overreacts to discipline or criticism.
26. Overly attentive to obsessive about hobbies, details, objects, or other.
27. Overly imaginative, obsessive-compulsive daydreaming or fantasizing, trouble discerning reality from fantasy.
28. Overly eager to please, people-pleaser, is taken advantage of by others, struggles to say "no."
29. Overly shy, quiet or mute in social groups/school, or social anxiety.
30. Overly unmotivated, outwardly lazy, defeatist attitude, minimal effort put into activities.
31. Overly stubborn, argumentative, close-minded, inflexible, or resistant esp. to change.
32. Hormonal changes: puberty, difficulties coping with PMS, menstruation infrequent or too frequent.
33. Difficulties sleeping, staying asleep, getting to sleep, general sleep disturbances.
34. Frequent nightmares or disturbed/unsettling dreams.
35. Frequent bedwetting, urinating, or difficulties controlling bowel movements.

36. Frequent forgetfulness, absentmindedness, makes careless mistakes, misplacing belongings, etc.
37. Repetitive motions or behaviors: Rocking, pacing, or stimming behaviors.
38. Has difficulty sustaining attention on enjoyed hobbies or play activities.
39. Poor follow-through on instructions, chores, tasks, failure to finish schoolwork, etc.
40. Disorganized: has difficulty organizing tasks and/or/in activities.
41. Avoids, dislikes, or is reluctant to engage in activities that require sustained effort.
42. Has or prefers imaginary friends or playmates over actual friends.
43. Fidgets with hands or feet, squirms, displays bodily symptoms of restlessness, nervousness.
44. Poor volume control, shouting, difficulty playing in leisure activities quietly.
45. Excessive to unmanageable energy, extreme hyperactivity.
46. Talks excessively, interrupts or speaks over others, cannot wait for turn to speak.
47. Withdrawn or excessive tendencies to withdraw, i.e., "shuts down."
48. Perfectionism, preoccupied with trivial matters, or struggles with prioritizing.
49. No appetite, refuses to eat or maintain body weight, or intense fear of becoming fat.
50. Perception of body shape and/or weight has undue influence on self-image or self-worth.
51. Denial of his/her actual weight or the seriousness of unhealthy body weight.
52. Peculiar eating habits: Eats in specific times or in amounts that is unusual.
53. Overweight, lacks self-control while eating, often overeats, or will binge eat.
54. Vomits, uses laxatives, or excessively exercised after eating to compensate for food intake.
55. Excessive compensative behaviors that occur twice/week over a period of 3 months.
56. Exhibits food hoarding or hiding behaviors, or possessiveness of food.

Medical

- Does your child have any allergies? No Yes if yes, please describe _____
- How would you describe his/her health/medical status? Excellent good fair poor
- Please describe any chronic / current medical conditions _____

Please list any medications she/he is taking for these conditions _____

- Please describe any past or present psychiatric, counseling or drug / alcohol treatment he/she has received

When/Dates	From Whom?	For What?	With What Results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- Please list any psychiatric medications he/she has taken in past or are currently taking

When/Dates	From Whom?	For What?	With What Results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- | | |
|---|---|
| <input type="checkbox"/> He / She is at... low medium high risk for HIV | <input type="checkbox"/> He / She is at... low medium high risk for Hepatitis |
| <input type="checkbox"/> He / She has been diagnosed with TB | <input type="checkbox"/> He / She has been treated for TB |
| <input type="checkbox"/> He / She had a blow to the head that causing unconsciousness | <input type="checkbox"/> He / She has had a blow to the head causing a concussion |
| <input type="checkbox"/> He / She received an injury that caused vision and / or hearing loss | |

- Does your child's father or paternal grandparents have any medical or psychological problems? No Yes, please describe _____

- Does your child's mother or maternal grandparents have any medical or psychological problems? No Yes, please describe _____

Family of Origin History:

1. Where was your child born and raised? _____
2. Describe child's relationship with his mother: _____
3. Describe child's relationship with his father: _____
4. Siblings Names Gender Ages Who do they live with Describe Childs relationship with each

Parents: To your knowledge has your child experienced any of following:

5. Has a parent or other adult in the household often ... Sworn at your child, insulted them, put them down, or humiliated them?
____ Yes ____ No Who? _____
6. Has a parent or other adult in the household acted in a way that made your child afraid that they might be physically hurt?
Who? ____ Yes ____ No Who? _____
7. Has a parent or other adult in the household pushed, grabbed, slapped, or thrown something at them? or Ever hit them so hard that they had marks or were injured? ____ Yes ____ No Who? _____
8. Has an adult or person at least 5 years older than your child... Touched or fondled them or touched their body in a sexual way? or Try to or have oral, anal, or vaginal sex with them? ____ Yes ____ No Who? _____
9. Has your child felt that ... no one in their family loves them or they are not important or special? Or their family doesn't look out for each other, feel close to each other, or support each other? ____ Yes ____ No
10. Has your child felt that ... they don't have enough to eat or that they have to wear dirty clothes? ____ Yes ____ No
11. Does your child feel that they have no one to protect them? ____ Yes ____ No
12. Parents or caregivers that too drunk or high to take them to the doctor when they needed it? ____ Yes ____ No
13. Were their parents ever separated or divorced? ____ Yes ____ No
14. Were any of your child's caregivers treated violently, pushed, grabbed, slapped, had something thrown at them, kicked, bitten, hit with a fist, or hit with something hard; or threatened with a gun or knife? Who? _____ ____ Yes ____ No
15. Has your child lived with a caregiver who was / is a problem drinker or using street drugs? Who? _____ ____ Yes ____ No
16. Was a household member depressed or mentally ill or did a household member attempt suicide? Who? _____ ____ Yes ____ No
17. Did a household member go to prison? ____ Yes ____ No Who? _____
18. Name and phone number of my child's personal / family physician.

Please use a separate piece of paper to comment on any additional information you believe is important regarding your child and your desire for your child to attend counseling.